Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for dates of service 8-7-01 through 3-22-01.
   b. By request of the Medical Review Division, an updated Table of Disputed Services was date-stamped received from the Requestor on 4-7-03. This table will be utilized and overrides the table initially filed with the original dispute.
   c. The request was received on 8-12-02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFAs
   c. EOBs and example EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. HCFAs
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 9-11-02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 9-12-02. No fourteen (14) day response was noted in the dispute packet. However, the Carrier's three (3) day response is reflected as Exhibit II of the Commission's case file.

4. Notice of Additional Information submitted by the Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Position statement taken from the Table of Disputed Services:
"The denial codes the carrier provided were: 1) Code 'M'….2) Code 'F'….The carrier has failed to provide an adequate statement regarding any methodology used to determine reimbursement in accordance with TWCC Rule 133.304(i)….(Provider) filed a Request for Reconsideration for all dates of service timely. The carrier's response regarding dates of service 8/7/01 – 8/27/01 stated that 'The original decision still stands. Reason being that per the carrier F&R 97799-CP for a non carf facility was reimbursed at $100.00 hour."

2. Respondent: Letter date stamped 8-14-02:
"For dates of service 8/7/01-8/27/01 – The Carriers' [sic] determination of fair and reasonable, or usual and customary is based on the Medical Fee Guidelines definitions of Single and Interdisciplinary programs and other/like carrier's who administer Workers' Compensation payments…. The carrier believes that our payment to this provider was fair and reasonable based on services rendered and documentation presented."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 8-13-01 through 3-22-02. Dates of service 8-7-01, 8-9-01 and 8-10-01 are not eligible for review, as they were not filed within the one year timeframe.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $2,330.00 for services rendered on the above dates in dispute.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $1,252.00 for services rendered on the above dates in dispute.

5. Per the Requestor's Table of Disputed Services, the amount in dispute is $1,078.00 for services rendered on the above dates in dispute.

6. The Carrier's EOBs deny additional reimbursement as "M – 426 – REIMBURSED TO FAIR AND REASONABLE; F – 790 – THIS CHARGE WAS REDUCED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE; T –270 – NO ALLOWANCE HAS BEEN RECOMMENDED FOR THIS PROCEDURE/SERVICE/SUPPLY PLEASE SEE SPECIAL *NOTE* BELOW; T – NOT ACCORDING TO TREATMENT GUIDELINES."

DOS	CPT or Revenue CODE	BILLED	PAID	EOB	MAR$	REFERENCE	RATIONALE:
8-20-01 8-27-01	97799-CP for all dates of service	$740.00 $185.00	$400.00 $100.00	M 426	No MAR DOP	MFG: Medicine Ground Rules (II) (G); TWCC Rule 133.307 (j) (1) (G); 133.307 (g) (3) (D); 413.011 (d); 133.304 (i); CPT Descriptor	The carrier has reimbursed the provider at $100.00 per hr. for Chronic Pain Management. The Provider has billed $185.00 per hr. CPT Code 97799-CP is reimbursed at fair and reasonable. Pursuant to Rule 133.307 (g) (3) (D), the requestor must provide "…documentation that discusses, demonstrates and justifies the payment amount being sought is a fair and reasonable rate of reimbursement….". The Provider has submitted example EOBs. However, none of the example EOBs submitted reflect the CPT Code 97799 all of them reflected CPT Code 64999. Therefore, there is no documentation that discusses, demonstrates, or justifies the hourly rate sought represents fair and reasonable. The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. However, the burden is on the Provider to prove that the fees requested are fair and reasonable. In this case, the Requestor has failed to support their hourly charge. Therefore, no additional reimbursement is recommended.
8-13-01 8-14-01	97799-CP for all dates of service	$555.00 $555.00	$300.00 $300.00	F 790 F 790	No Mar DOP	TWCC Rule 133.304 (c); CPT Code Descriptor	TWCC Rule 133.304 (c) states, "The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's actions(s). A generic statement that simply states a conclusion such as "not sufficiently documented" or other similar phrases with no further description for the reason for the reduction or denial of payment does not satisfy the requirements of this section." No maximum allowable reimbursement (MAR) exists for CPT Code 97799-CP. This code is reimbursed at fair and reasonable. Therefore, the Carrier has failed to comply with 133.304 (c) and has failed to support its denial as there is no MAR value for this code. Therefore, additional reimbursement is recommended in the amount of **$510.00**. ($1,110.00 billed -$600.00 paid = $510.00 balance).
3-22-02	64999	$295.00	$152.00	T 270	DOP	TWCC Advisory 2002-11 CPT Code Descriptor	Pursuant to Advisory 2002-11, "The Commission clarifies that, since the Commission's treatment guidelines abolished and repealed, and until the Commission adopts any new treatment guidelines, the payment exception code 'T' is no longer valid and cannot be used to reduce or deny payment by an insurance carrier for dates of service on or after January 1, 2002. Therefore, reimbursement is recommended in the amount of **$295.00.**
Totals		$2,330.00	$1,252.00				The Requestor **is** entitled to additional reimbursement in the amount of **$805.00.**

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$805.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 11th day of April 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

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